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ABSTRACT

Described are the diagnostic procedures employed for multiply and visually handicapped children 3-12 years of age functioning at the preschool level at the Boston Center for Blind Children. Diagnosis is seen to serve as a key to understanding the child and as a basis for planning services. Described is the center setting which serves six multiply handicapped children 4 days a week with a staff of one teacher and two teacher aides. Explained are prestudy procedures including referral, application for admission, arrival, and presence of one parent (usually the mother) throughout the diagnostic study. Noted are the roles of each of the following staff members in the diagnosis: the social worker (who interprets the family situation and serves as a parent advocate), the pediatrician (who interprets medical findings in nontechnical terms to team members), the psychiatrist (who focuses on the whole child from a psychiatric viewpoint), the educator (who observes the child and orders the child's needs as priority items), the psychologist (who focuses on the child's level and mode of functioning through psychological evaluations). The 6- to 7-day diagnostic study is said to culminate in the diagnostic case conference at which staff members present their findings and plan treatment procedures. (DB)

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# DIAGNOSTIC STUDY FOR THE DAY PRESCHOOL AT THE BOSTON CENTER FOR BLIND CHILDREN

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# DIAGNOSTIC STUDY FOR THE DAY PRESCHOOL

# AT THE

# BOSTON CENTER FOR BLIND CHILDREN

## Introduction

A revered colleague of mine was recently quoted as saying, "Diagnostic study is a cop-out" and so it is if services stop there or, indeed, if the results of the study in any way fail to lend themselves to the establishment of services tailored to fit the child's special needs. However, in planning appropriate programs for multi-impaired children, we consider it absolutely essential to start by seeking as much knowledge as possible about a child's strengths and handicaps in a multi-dimensional sense (social, physical, mental, emotional, sensory, and educational). Only in such a way do we feel it is possible to establish appropriate goals for a child, locate the most suitable setting in which his current needs can be met, and develop a program of activities geared toward the accomplishment of the stated goals.

Therefore, when the Boston Center for Blind Children started its federally funded day preschool program three years ago, we sought to adapt the program of diagnostic study (which had long been in use at the Center) to the particular needs of this population of preschool multi-impaired children.

## Scope of Diagnosis

We think of diagnosis more as a key to understanding the child, and hence a basis for sound planning for him than as a process of fitting him into a definite clinical diagnostic category. This understanding for which we strive in our diagnostic procedures recognizes the probable multiplicity of etiological factors in the creation of the child's difficulties. These difficulties seem to evolve from interaction

Scope of Diagnosis (Continued)

between constitutional factors and maturational processes on the one hand and environmental influences on the other. Therefore, diagnostic study requires investigation into such relatively constant factors as the child's physical self (including his "mental equipment" and other constitutional factors insofar as it is possible to evaluate them). These constant factors must then be viewed in relationship to the ever-changing processes, such as the environment in which the child lives, the many forces which are influencing and have influenced his growth and development. Then, these two sets of factors (the relatively constant and the ever-changing) must be considered in the light of the child's present level of accomplishment, the presenting problem, the rate at which he has made and is making progress in various areas of growth, the way he perceives and reacts to himself, to members of his family, and to the world around him. Diagnosis consequently involves such questions as What is the child like?, Where is he - in the developmental continuum, in his physical environment, in his emotional development?, How does he function?, How does he feel toward the people with whom he lives, and how do they feel about him?, How did he get to be the way he is?, What is the best possible approach to helping him?. The foregoing questions recognize the child's problems and limitations (which we hope to remove or alleviate). It is equally important to recognize his strengths, for on these will an effective treatment plan depend.

At our present stage of knowledge, it is impossible for us to acquire all this information about any child. It is particularly difficult to evaluate the constants - the constitutional factors present in the preschool, multi-impaired child. We have no completely reliable methods

Scope of Diagnosis (Continued)

of evaluating all such constitutional factors in isolation either from each other or from the changing forces. In dealing with multi-handicapped preschool children, for example, no equation allows us to add a specific degree and type of visual limitation even to a clearly understood mental limitation, to toss in the most important aspects of the child's personality and developmental level, see these mixed with pertinent factors in the youngster's environment and arrive at a fool-proof composite picture of the child which clearly delineates his needs.

It is imperative that we frankly admit and allow for these limitations in our knowledge, and the shortcomings in our tools and techniques of diagnosis, for they make it impossible to arrive at a truly complete diagnostic understanding. These shortages make it the more imperative that we use all of the skills, techniques and tools which are available to us--that we use them in a very thorough, though cautious and critical manner, that we constantly seek new and improved procedures to help us achieve greater refinement in both the science and the art of diagnosis.

The Setting

The day preschool of the Boston Center for Blind Children has been operating on Monday through Thursday from 9:00 to 3:00 p.m. Six multi-impaired preschool children are met each morning by their teacher (who has specialized background at the master's level in the education of visually handicapped children), two teacher assistants (college graduates with special interest in these children), sometimes a student teacher (currently a candidate for the master's degree from Boston College in the education of the handicapped), and often by a participating parent. Other professional people (such as mobility instructors, speech

The Setting (Continued)

therapist, psychologist, social worker, child psychiatrist, audiologist) are involved in the program from time to time.

Each child has been seen individually in diagnostic study as a result of which individual goals in self-help, language, motor, social, and orientation and mobility skills have been established for him and a program of activities prescribed. Progress toward the accomplishment of these goals is evaluated weekly and the goals changed as the child's progress indicates. Every sixteen weeks, a revaluation in depth is conducted. This serves as a further check on the appropriateness of the goals, the program, and the associated activities for this particular child.

While the ages of the children range approximately appropriately from three to twelve, all are functioning on a preschool level, and all, due to the severity of their several handicaps, are substantially below the level expected of a child of ~~his~~ that age. The picture of the composite group which a casual observer sees is little youngsters engaged in various play activities (usually parallel play), very little communicative speech, some children having difficulty with orientation in space and in mobility, an occasional child with a hearing loss or question of such loss, all children with severe visual limitations, and each functioning well below the level expected for a child his age without serious handicap. It may be important here to note that, although this is a bird's eye view of the group of children seen daily, several youngsters have made sufficient progress in the day preschool to have been "graduated" into other specialized programs and are now progressing beyond the preschool level.

The Setting (Continued)

It is into this setting, then, that the child who comes for diagnostic study is seen.

Pre-Study Procedures

Let us turn our consideration to the actual procedures involved in diagnostic study, how these are carried out by representatives of the various disciplines, and how the findings are integrated into a unified understanding of the child which allows for wise and constructive treatment planning, education, and management.

The youngster is usually referred for diagnostic study by another agency, a school, a physician, or our own community based program.

Prior to admission, the parents complete a rather lengthy application for services (see appendix) which gives the more or less concrete information about the child, his difficulties, his family background and life experiences. The parents also provide waivers for the obstetrician who delivered the baby, the pediatrician, the ophthalmologist, any other physicians, schools, or agencies who have had contact with the child. Complete reports are sought from all of these people. Therefore, before the youngster is seen at the Center, a good beginning has been made toward understanding his history.

Then comes the day of admission. Often both parents arrive with the child (and sometimes a sibling or two), but in many cases, the father is not able to stay through the entire study. One parent does remain, and her presence throughout diagnostic study has proved to be extremely valuable. It is often very helpful to the youngster to have this important person with him in his adjustment to the new environment. Mother's presence also allows us to understand the subtleties of the mother-child relationship in a more thorough manner than could be

Pre-Study Procedures (Continued)

accomplished in brief visits or office interviews; and she is able to give us a great deal of information which the child himself is unable to relate. Further, Mother's presence often permits us to offer her certain help which may be useful in her work with the child after they return home. It also allows her to become well enough acquainted with the staff at the Center so that she can feel free to turn to us for continuing assistance in the future. Perhaps the most important reason for requiring the mother to participate during diagnostic study is that it keeps this vitally important person maximally involved in our mutual efforts to achieve better understanding of the child. Her presence allows for much more rapid sharing of the mother's developing understanding and our own.

Child and parent normally begin the study period on a Monday, with the expectation of daily attendance in the day preschool until the study ends on Wednesday of the second week. Let's look now at what the various members of the staff seek to learn about the youngster during the study.

The Social Worker

The social worker enters the picture with a "new family" at the point of referral. Her initial effort is to interpret the program to the family and to help them to determine whether this is a service they need and want. She will stay in close touch with the family, arranging a date for the diagnostic study to begin, and helping where she can--perhaps simply assisting with completing the application or aiding with family problems that may arise because of the study, such as assisting in finding qualified care for other children while mother is away or

The Social Worker (Continued)

arranging transportation to and from the Center if that poses a problem.

Then, when the day comes for the child to start the study, the social worker (hopefully, by now, a friend of the family) meets the family at the Center, introduces them to the day preschool staff, and generally assists them in starting the study as comfortably as possible.

Her two most important responsibilities are to interpret the family situation to colleagues in order to help them understand the impact of the environment on the child we are seeing, and to become the parent advocate on the team. Both of these responsibilities require a fairly intimate knowledge of the family and their experiences. Often, even with a child of preschool age, parents have had unfortunate experiences which haven't met their needs. Too frequently have they been given variations on the theme of "Nothing can be done. Put him in an institution" or "There are no services which can help you." This, on top of all the mixed emotions which parents experience at the advent of a multi-handicapped child, can be mightily discouraging! It becomes the responsibility of the social worker to help the parents achieve a more hopeful attitude with its concomitant--greater energy to invest in their child's future, while avoiding the obvious pitfalls of raising their hopes to an unrealistically high level.

To learn the information she needs to meet these vital responsibilities, she talks frequently with the parents, sometimes in formal interviews and sometimes in quite casual conversations.

Gaining other information she needs to share with the team (such as

The Social Worker (Continued)

what resources exist for this child in his home community) usually requires a number of contacts with people in that community other than the parents.

The Pediatrician

The pediatrician's contribution to the diagnostic study of a preschool multi-impaired child is of critical importance. He must study the child's usually complicated medical history, add the indicated current examinations, synthesize the data, make whatever medical arrangements are necessary, and, last but far from least, he must interpret all of these findings in non-technical terms to all team members (including parents) who must integrate this information into their planning for the child and who must share the responsibility for on-going medical care.

By the time the child arrives, we have usually received reports from the obstetrician who delivered the baby, the pediatrician who has cared for him, the ophthalmologist, and any specialists who have been consulted, as well as reports from any hospitals which have been involved in his care. While these reports are usually immensely helpful, they occasionally are sketchy and lacking in necessary detail. In this event, the pediatrician conducts a further search for missing information.

When the child comes for study, the pediatrician interviews the parents and obtains a first hand report, a detailed medical history since birth. In addition to the usual pediatric history, with these children, the physician makes particular inquiry into such questions as convulsions; he also has special interest in nutritional and developmental history.

Since it remains important in the pediatric evaluation of a child for the Center's preschool, I would like to quote from a paper by the

The Pediatrician (Continued)

late Dr. Kenneth F. Sands, a former pediatrician at the Center, on the actual medical examination.

"The technique of the actual medical examination for these children is somewhat unusual. This has been found necessary because it has been usually true that the child is apprehensive and as a result, unless special efforts are made he is often unlikely to be cooperative. On first meeting the child, it has been not only very rewarding, but very pleasant to talk with him and to play with him in a friendly informal manner in the presence of parents. In fact, this part of the examination often reveals some of the most important medical information. For example, it is usually here that one can determine whether the child has any obvious motor disabilities or incoordination, and one has an opportunity to observe the gait. In addition, it usually is apparent at this time whether or not the child has any useful vision and whether he can hear. I would like to reinforce the importance of making evaluation of the amount of vision and hearing and relating these evaluations as part of the medical report. Also, certain other obvious, but important, observations are made at this time, such as the general nutritional status of the patient. Following this initial period of informal play it often then becomes possible, having gained the child's cooperation, to proceed with a formal medical examination. Here, too, and this is generally true of pediatrics in general, one does not examine a child in the same order that one would an adult. Much of the examination is a great deal more satisfactory if the unpleasant maneuvers are deferred until the very end. For example, one does not gag a child with a

The Pediatrician (Continued)

throat stick the first minute one sees him, because if one does, it is pretty certain that the rest of the examination will be completely unsatisfactory. For that reason looking at the ears is done last. In instances when the child has been apprehensive and recalcitrant despite efforts to gain his cooperation it seems wisest to defer the detailed examination to a later date when he has had more opportunity to become acclimated to his new environment.

As to the appraisal of the neurological status, while it is important, if possible, to do a detailed neurological examination including reflexes etc., it has already been noted that a great deal of information can be gained by simply observing the child in spontaneous play and activity. This has been well emphasized many times by Dr. Bronson Crothers, retired chief of neurology of the Children's Medical Center. He has repeatedly and dramatically demonstrated a mild hemiplegia in a child whom a medical student has declared to have a negative neurological examination, by the simple expedient of observing the gait, the only part of the examination the student had failed to do.

Occasionally, special problems are noted in the original medical evaluation which may be in the field of orthopedics, otolaryngology, etc. and we are fortunate in having through our affiliation with the Children's Medical Center the opportunity to obtain specialized help in the diagnostic study through this resource.

The Pediatrician (Continued)

Special laboratory procedures as part of the medical study have not often been indicated. However, when such laboratory work does become important for a particular child, once again we turn to the facilities of the Children's Medical Center. While there is much laboratory work which would be of considerable research interest, it has been the general philosophy of the Center not to perform any laboratory work except as would contribute to the care and understanding of a particular child. Perhaps it seems a missed research opportunity not to obtain electroencephalograms, for example, on all of the patients admitted, but even such a benign procedure as this can be upsetting to a child.
In order to participate effectively in planning for a child, the pediatrician completes his appraisal by conferring with the other members of the professional and non-professional staff."

The Psychiatrist

The psychiatrist is another member of the diagnostic team to whom we look for understandings vital to helping us establish the most suitable possible plan for a child.

He examines the child directly, he examines indirectly through discussions with other team members, and he interviews the child's parents. He seeks to evaluate the whole child. He is thus concerned with intellectual, social, emotional, and physical factors and how all of these interact. He can learn much from observing the child with his parents, with other children, with staff members, with objects in his environment, and finally in his interrelationships with him.

The Psychiatrist (Continued)

His final responsibility in diagnostic study is to bring all of these observations together, evaluate them in the light of his clinical training and experience, and then interpret this child's needs from a psychiatric viewpoint in such a way that staff will be able to talk these important factors into consideration in program planning.

The Educator

The teacher is the member of the diagnostic team who spends the most time with the child during the study period. She has an initial opportunity to observe how the youngster fits into and adaps to a new environment. She sees how the child relates to play equipment, to other children, to adults. She can evaluate his ability to acquaint himself with and master his environment. She can evaluate his competency in self-help in great detail. She studies his communication skills (verbal and non-verbal). She becomes aware of his behavioral strengths and weaknesses.

She assesses him principally in self-help, language, motor, social, and orientation and mobility skills. She then attempts to "order" the child's needs as to priority and decide whether she feels these most pressing needs can best be met in the day preschool or elsewhere.

The Psychologist

The purpose of psychological evaluation in the general scheme of diagnostic study is three-fold, seeking to answer these broad questions--"At what general level is the child functioning?", "How is he functioning?", and "Why is he functioning in this way?".

No single procedure or set of procedures provides answers to any

The Psychologist

of these questions. There is no single test or set of tests which will give conclusive answers.

The first step in psychological evaluation is not different from that of other members of the diagnostic team--that is, a careful study of all pertinent facts in the child's history. At what ages did he accomplish specific skills, and under what circumstances? What has been his general rate of development in the past? Does his medical history tell us that he has had long bouts of illness, frequent or lengthy hospitalizations, convulsions, or other difficulties which need to be taken into account? What has his family situation been? Have the parents been able to relate to him in such a way as to provide an optimal environment for his growth? If this has not been the case, what problems have the parents experienced, and how have these interfered with their efforts to help the youngster in his development? Have prior psychological studies been made which may, through comparisons with present findings, add to our understanding?

From careful review of the child's medical and social background from interviews with parents, and from observation, the psychologist can learn many things, including:

1. How the child relates to the most important people in his life (his parents),
2. How he relates to other adults and to children,
3. How he uses play and educational equipment,
4. His demonstrated competence in the various self-help skills,
5. The extent and level of his interests,
6. Whether he seems to be markedly passive or unusually aggressive,

The Psychologist (Continued)

7. The state of his general happiness,
8. The appropriateness and extent of his emotional responses in a variety of situations,
9. An assessment of the influence of his handicaps in addition to his blindness,
10. Information as to the manner in which he uses any residual vision he may have.

In addition to this information gleaned from the observations of others, the psychologist can gain appreciably in her understanding of the child through herself engaging in play sessions with him which sessions can be structured according to the nature of the child's difficulties and the clues already learned.

Some more or less standardized tests for blind children have proved to be of great value in adding to our understanding of a given child's status. However, it should be emphasized that test results must be interpreted carefully in the light of what is already known about the child. They should not be used as the sole evidence on which a statement regarding competence is based.

For children who do not yet use speech to communicate (most of the children we see), the Adaptation of the Vineland Social Maturity Scale by Maxfield and others can be most helpful. Again, as Dr. Maxfield has repeatedly pointed out, results of the use of this scale must be interpreted with great caution since they are influenced by many factors other than the child's inherent ability. When these other factors are taken into consideration, knowledge of the child's level of social competence as reflected in the scale can be of real diagnostic usefulness.

The Psychologist (Continued)

When employing the Maxfield Scale it is also important to recognize that while social competence is related to intelligence, they are not identical, and this scale does not purport to measure intelligence.

Dependent upon the child's abilities and the general nature of his problem, the examiner selects those techniques which seem most likely to be helpful. Then, by the end of the diagnostic study period, she is able to state certain facts with assurance and to suggest probable explanations for others. It is always possible to describe the child's present level of general social and intellectual functioning and to delineate the areas of his greatest competence as well as to isolate the areas of functioning in which problems exist. It is not always possible to state with assurance exactly what is causing his difficulties. However, the emergent picture of the child in relationship to his environment allows for an understanding of the strengths in his situation as well as an understanding of those factors which may be adversely influencing his growth. The question of whether or not these factors which we know to be antagonistic to mental and emotional health account, in whole or in part, for the child's difficulties must be considered jointly with other members of the diagnostic team.

Diagnostic Case Conference

The case conference culminates the six to seven day diagnostic study, when each member of the team presents his findings. By the end of these individual presentations, we perceive the child more clearly as possessing a physical, mental, emotional, and social self with attributes and characteristics suggestive of certain basic constant factors to be dealt with. We see this complex being functioning in an equally complex environment, and we seek to understand the individual, his environment, and the ways in which they are influencing each other.

Diagnostic Case Conference (Continued)

When this diagnostic picture is thus evolved and treatment recommendations thought out jointly in the case conference, the director meets with the parents to interpret the findings to them and to help them take the necessary steps to pursue the treatment plan.

If it is felt that the child can be served best at present in the day preschool, the findings of the study are then used to establish goals for him (in cooperation with his family) and plans are made for his attendance and for his family's close involvement with the program. If the day preschool is not considered the plan of choice for him, we continue working with other agencies (each of whom receives a complete report of our diagnostic study) to arrange for his inclusion in whatever program seems optimum for his current needs.

ELK/ml

# APPENDIX

APPLICATION FOR SERVICES
BOSTON CENTER FOR BLIND CHILDREN
147 South Huntington Avenue
Boston, Massachusetts 02130
BEacon 2-1710

Date of Application_____

Child's Name_____ Date of Birth_____

Nickname_____ Place of Birth_____

Street Address_____ *Religion_____

City_____ *This item only necessary for children who remain in residential treatment.

State_____ Telephone number_____

Mother's First Name_____ Maiden Name_____

Date of Birth_____ Birthplace_____ General Health_____

Education_____ Occupation Before Marriage_____

Present Occupation_____ Salary_____

Father's Name_____ Date of Birth_____

Birthplace_____ General Health_____

Education_____ Occupation_____ Salary_____

If mother and father do not live together, please describe situation_____

_____

_____

Others in the Home:

| Name | Relationship to this child | Birth-Date | Health |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

(If others not mentioned above live in the home please list them on the back of this sheet. Also, if there are other children, even though they do not live at home, please list them on the back of this sheet.)

If family has lived at other than the present address since this child's birth please give details below, including place, dates and any unusual circumstances or events occurring at that time.

Has this child been consistently in this mother's care since birth?_____
If not, please give details_____

Does child sleep in a bed or a crib?____Does he (or she) have own room?_____

If not, please describe sleeping arrangements_____

Medical background: (Consult your obstetrician for details)

Mother: Prenatal History and Date of Last Menses:_____

Length of gestation for this child:_____Type of delivery_____

Anesthesia_____How many pregnancies?_____

How many still births?_____How many miscarriages?_____

Describe all complications of pregnancy-bleeding, medications, etc._____

(Consult your Obstetrician or Pediatrician)
Child: Birth-weight_____Duration of initial hospitalization_____

How long was baby in an incubator?_____Was oxygen given?_____

How long was oxygen given?_____Describe complications such as convulsions, turning blue, etc._____

Type of feeding (breast, evaporated milk, etc.)_____

DEVELOPMENTAL HISTORY: (For each of the following which the child has accomplished give approximate age of accomplishment)

Holding head up_____Sitting with help_____Sitting alone_____Walking with help_____Standing alone_____Walking alone_____Saying word sounds (da-da, ma, ma)_____Repeating two or more real words_____Putting words together_____ Using pronouns correctly_____Following simple commands (pat-a-cake, no, no)___ Bladder training: day_____night_____Bowel training: day_____night_____ Feeding self hard substances from hand_____Giving up bottle_____ Feeding self with spoon_____Holding own cup_____Undressing self_____ Dressing self_____Brushing own teeth_____Bathing self_____Using fork for eating_____Using knife for cutting and spreading soft foods_____ If child menstruates, state date of onset_____Has child regressed in any accomplishments:_____

Eating habits at present: (type of food, degree of self feeding)_____

_____

Sleeping habits:_____

Describe child's usual behavior in terms of degree of activity, happiness, or unhappiness, fears, mannerisms:_____

_____

_____

Describe child's play (alone or with others, kinds of playthings)_____

_____

_____

What other agency or agencies, if any, have given service to this child_____

_____

_____

_____

Diseases: (Please give dates)

Chicken Pox_____ Mumps_____ Measles_____ Diphtheria_____

Roseola_____ Scarlet Fever_____ German Measles_____ Whooping Cough_____

Allergies_____ Other Illnesses (Give name and dates)_____

_____

_____

Diagnostic Measures: (Give dates and obtain results from physician who did them)

Wasserman or Hinton_____ Tuberculin (Method)_____

Hemoglobin (Method)_____ Urinalysis_____

Electroencephalogram (EEG)_____

| IMMUNIZATIONS (Give Dates) | INITIAL 1st | 2nd | 3rd | BOOSTERS 1st | 2nd | 3rd |
|---|---|---|---|---|---|---|
| Diphtheria | | | | | | |
| Whooping Cough | | | | | | |
| Tetanus | | | | | | |
| Polio | | | | | | |
| Smallpox | | | | | | |
| Measles | | | | | | |
| Mumps | | | | | | |

THE ABOVE DIAGNOSTIC AND PROTECTIVE MEASURES ARE TO BE COMPLETED ON EVERY APPLICANT FOR THE RESIDENTIAL CENTER BEFORE ADMISSION.

Present Health of Child:

Height_____ Weight_____ General Health_____

Eye Diagnosis_____ Apparent amount of vision (Right)_____

(Left)_____ Age of onset of blindness_____ Additional Handicaps_____ Convulsions_____

Cerebral Palsy_____ Hearing_____ Speech_____

Medications (Past)_____

Medications (Present)_____

Describe any operations, hospitalizations, or unusual nutritional history:

_____

_____

_____

Has this child ever attended nursery school?____Dates: From_____

To_____Name of School_____

Address of School_____

Has this child ever attended kindergarten or elementary school?_____

Dates: From_____To_____

Name of School_____

Address of School_____

Principal or Superintendent's Name_____

If you are requesting diagnostic study, please describe the nature of the problem which causes you to seek such study_____

_____

_____

(use back of sheet if necessary)

Check those services which you feel are needed for this child:

_____Diagnostic Study

_____Home Visiting with Training Suggestions

_____Guidance in School Planning

_____Psychological Evaluation

_____Pediatric Evaluation

_____Residential Treatment (if this item is checked, use the back of this sheet to state specifically and in detail why this type of care seems advisable)

_____Other (specify type)

_____

Signature of person referring this child

_____

Relationship to child

WAIVER

The private obstetrician who delivered _____

is Dr. _____ whose address is _____
number and street

_____.
city state zip code

I authorize him to send a complete report of his contact to the Boston Center for Blind Children, 147 South Huntington Avenue, Boston, Massachusetts 02130.

_____
Signature of parent or guardian

---

WAIVER

_____ was delivered at _____
child's first and last name hospital

_____ by a hospital staff doctor.
hospital address

I authorize said hospital to send a complete report of their contact to the Boston Center for Blind Children, 147 South Huntington Avenue, Boston, Massachusetts 02130.

_____
Signature of parent or guardian

---

WAIVER

The General Practitioner or
The Pediatrician who care for _____ is
child's first and last name

Dr. _____ whose address is _____
number and street

_____.
city state zip code

I authorize him to send a complete report of his contact to the Boston Center for Blind Children, 147 South Huntington Avenue, Boston, Massachusetts 02130.

_____
Signature of parent or guardian

---

WAIVER

The ophthalmologist (eye specialist) who cares for _____
child's first and last name

is Dr. _____ whose address is _____
street and number

_____.
city state zip code

I authorize him to send a complete report of his contact to the Boston Center for Blind Children, 147 South Huntington Avenue, Boston, Massachusetts 02130.

_____
Signature of parent or guardian